

Contact with general practitioners and differences in health status among people aged over 85 years

ANN P. BOWLING

SUMMARY. A survey of the health and social service needs of all people aged 85 years and over was commissioned in 1986 by members of City and Hackney health authority and Hackney social services department. In 1987, 662 people who lived at home were traced from family practitioner committee records and interviewed.

Eighty six per cent of respondents had consulted their general practitioner in the 12 months before the interview. Analyses showed that those who had not consulted within the 12 month period reported fewer physical and psychological symptoms, consumed less prescribed medication and reported better emotional well-being than those who had consulted more recently. However, the survey detected a considerable amount of unreported morbidity among both recent consulters and non-recent consulters. This finding questions the suggestion that the problem of under-consultation among elderly people is exaggerated but recommends that in studies of case finding attention should be focused on unreported morbidity rather than infrequent consultation.

Introduction

ALTHOUGH consultation rates increase with age,¹ a number of studies in general practice have reported that people aged over 65 years tend to under-consult and would benefit from screening programmes.²⁻⁹ A recent review of 23 studies by general practitioners based on screening elderly people, found that all but three reported much 'unmet need'.¹⁰ This evidence was apparently influential in the recent white paper on improving primary health care, which suggested that the government might encourage primary health care professionals to conduct 'health checks' for elderly people.¹¹ Ford and Taylor, however, have argued that the problem of under-consultation among elderly people is exaggerated¹² and Buckley and Williamson have cautioned against medical screening, recommending case finding programmes directed at functional assessment.¹³

Case finding programmes are believed to be more economically viable than mass screening exercises, given that many elderly people are relatively fit, but case finding needs to be selective. Taylor and Ford suggested that very old age (85 plus years old) and recent discharge from hospital were the two most worthwhile indicators of high vulnerability.¹⁴

One strategy for case finding would be to concentrate on people who had not consulted their general practitioner for some time. There is evidence, however, that this would be wasteful in terms of resources, since the majority of signs and symptoms identified by medical examination are either known to the general practitioner or not relevant to the patient's health and well-

being.^{15,16} Studies have reported that the health of elderly people with low consultation rates is either similar to,¹⁷ or more favourable than,¹⁸ those with higher consultation rates. However, does the extent of this reduced morbidity justify excluding this group from extra attention in case finding programmes? More information about this group is needed, particularly in relation to the non-medical reasons for their lower consultation rates. For example, few studies of the sociodemographic factors influencing consultation patterns have focused on the elderly.

This study was commissioned by members of City and Hackney health authority and Hackney social services department. It was decided to concentrate on people aged 85 plus years because their numbers are increasing faster than other age groups in the population and little information exists about their health and circumstances.

The aims of the survey were to identify all people aged 85 plus years living at home in the borough and to measure their need for health and social services, functional ability, life satisfaction, psychiatric disturbance and level of informal support from family and friends.

Method

Patients' names and addresses were obtained from family practitioner committee lists and, after checking against the electoral register for patients who had died or moved, a sample of 1041 remained. A letter was sent to each patient explaining the purpose of the survey and this was followed by a personal visit from one of 16 interviewers (mostly unemployed university graduates with between one and five days formal training).

Of the 1041, 25% refused to be interviewed (often commenting that they were 'alright' or 'did not need anything'), and 11% were never at home or did not answer the door when the interviewers called (despite five repeat visits at different times of the day). Six hundred and sixty two people were successfully interviewed, but not everyone answered all the questions. Although this is just under two thirds of the total eligible sample (64%) it was regarded as a fairly high response rate for very elderly people, living in an inner city area with a high crime rate. Local general practitioners were able to provide some basic information about the non-responders which indicated no significant differences between them and the remainder of the sample in terms of age, sex, reported depression and mobility (housebound or not), and consultation patterns. This gave the researcher confidence that the sample was representative of people aged 85 plus years living at home in the district and it was not necessary to weight the answers to allow for differences between responders and non-responders.

Measures

Four measurement scales were supplemented with individual items, symptom checklists and open ended questions.

The measure of functional ability used was derived from Townsend's measure of ability to perform activities of daily living.^{19,20} The number of tasks was extended to 23, to take account of areas where help was available from health and social services professionals. This was tested for inter-interviewer reliability and internal consistency. The scale included a measure of dependency and details of professional and informal carers.

A.P. Bowling, MSc, PhD, senior lecturer, Health Services Research Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, and Department of Community Medicine, City and Hackney Health Authority.

© *Journal of the Royal College of General Practitioners*, 1989, 39, 52-55.

Life satisfaction and morale was measured with Neugarten's life satisfaction scale.²¹ This has been well tested for reliability and validity, and was designed for use with elderly populations. A wide variety of content areas is tapped, ranging from happiness to satisfaction with past and present life. It provides a global measure of well-being, although individual items are also of value as indicators of feelings. The possible range of scores is zero (low life satisfaction) to 20 (high life satisfaction).

The general health questionnaire was administered to assess psychiatric disturbance. This was designed and tested by Goldberg,²² as a self administered screening test for use in community settings. It does not attempt to detect mental subnormality, senile dementia, psychoses or mania (an item on confusion was included in the symptom check list and interviewers made separate assessments of any problems with confusion). It is a well tested method of detecting psychiatric disturbance and correlates well with psychiatric diagnoses of depression. The short 28 item version was used. The range of scores is from zero to 28; the threshold score was five, over which value respondents were rated as 'cases'.

Finally, social networks and support were measured with the social network scale, which has also been well tested for reliability and validity.²³ This asks respondents for details of people who are significant to them and with whom they are in at least monthly contact (the social network), the number and proportion of relatives in the network, the density of the network (relationship of network members to each other), and the number of people who provide emotional support (confidantes). Additional questions were asked about household composition, marital status, number of, and contact with, children and feelings of loneliness.

Nineteen per cent of respondents were unable to complete the general health questionnaire, and some other items on the questionnaire owing to problems with confusion and/or combined poor sight and hearing. For each of these respondents, the questionnaires were supplemented with proxy information from carers about their circumstances and need for health and social services.

Analysis

The data were analysed using the statistical package for the social sciences (Xth version), and non-parametric statistics were applied to the results presented here.^{24,25}

Results

Characteristics of the sample

Ninety per cent of the sample were female, and 10% were male. Three quarters were aged 85–89 years, 21% were 90–94 years, and 4% were 95 years and over. Sixty one per cent lived alone.

Eighty six per cent of respondents had seen their general practitioners within the last 12 months, and most (61%) had seen their general practitioners within the last three months (Table 1). Just over a third of respondents (36%) had experienced a major illness, operation, accident or fall in the 12 months prior to the interview.

Twenty seven per cent of respondents achieved a score over the threshold of five with the general health questionnaire, indicating possible anxiety and depression.

The average score with Neugarten's life satisfaction scale was 13, with 67% of respondents scoring at or below this level and 40% scoring less than 10. One-third of respondents scored six or less, indicating a very low overall life satisfaction.

About three quarters of respondents had no difficulties at all with personal care tasks, such as dressing and washing, although far more were unable to do odd jobs around the home (61%),

Table 1. Time elapsed since last contact with the general practitioner.

	Percentage of respondents (n = 628)
Less than 7 days	12
More than 7 days but within 1 month	26
More than 1 but within 3 months	23
More than 3 but within 12 months	25
Between 1 and 2 years	10
More than 2 years	4

n = number of respondents.

cut toenails (53%), go shopping (53%), do the laundry (46%), get in or out of the bath (38%), do the housework (36%), or get about outdoors (31%). Relatives were the main helpers, except for bathing, cutting toenails and housework, where professionals provided most help. Ninety seven per cent of those with some degree of difficulty had help with at least one task of daily living. A high level of support and help from relatives and friends was found, with 95% of respondents being in regular and frequent contact with relatives and friends, and receiving help and support from someone.

Table 2 shows the current health symptoms reported by the total sample. Most of the sample (96%) reported at least one symptom from the checklist presented to them: 25% of the total sample reported between one and two symptoms, 39% reported between three and five and 32% reported six or more. Respondents were also asked whether they had reported these problems to their general practitioner. Table 2 shows that a considerable amount of possibly manageable morbidity had not been reported to the doctor. About a third of respondents had

Table 2. Proportion of respondents reporting symptoms at interview and proportion who had consulted the general practitioner about them.

	Number (%) reporting symptom ^a	Percentage of those reporting symptom who had not seen GP about it ^a
Aches/pains/stiffness in muscles/joints	457 (70)	20
Poor eyesight (even with glasses)	344 (52)	12
Poor hearing (even with aid)	259 (40)	35
Trouble with feet	290 (45)	23
Sleeplessness	242 (37)	39
Forgetfulness	230 (35)	81
Giddyness	217 (33)	36
Nerves/stress/depression	212 (33)	48
Constipation	213 (33)	24
Incontinence	187 (29)	18
Indigestion/heartburn	164 (26)	33
Chest pains/heart trouble	137 (21)	7
Bronchitis	137 (21)	10
Headaches	110 (17)	34
Loss of appetite	104 (16)	55
Confusion	104 (16)	65
Abdominal pain/discomfort	92 (14)	23
Piles	50 (8)	22
Alternatively constipated/loose	33 (5)	13
Passing blood/tar motions	24 (4)	9
Vomiting blood	(4 people)	(1 person)

^aNumber of respondents to each item varied from 633 to 656.

not consulted over poor hearing, giddyness, headaches, indigestion and heartburn. Just under a quarter had not consulted over problems with their feet, 18% had not reported problems with incontinence and other urinary problems, and 22% had not consulted over problems with piles. Large proportions had also not consulted their doctors over problems with forgetfulness, confusion, loss of appetite, nerves/stress/depression, and sleeplessness.

Comparison of recent and non-recent consulters

No differences were found with age, sex, marital status, type of social network, perceived social support or reported feelings of loneliness between those who had consulted their general practitioner in the last year and those who had not.

Table 3 shows that the less recent consulters over the 12 months appeared to be fitter than recent consulters: they reported fewer symptoms of physical illness and were less likely to be taking prescribed medication, they were less likely to have experienced a major illness, operation, accident or fall within the 12 months prior to the interview, they had better mental health (lower general health questionnaire scores) and greater life satisfaction.

Those who had not seen their general practitioner for over a year reported the fewest number of symptoms: only 8% currently experienced seven to 15 symptoms in contrast to 18% of responders who had consulted between three and 12 months before and 28% of those consulting within three months before the interview (chi-square test: $P<0.05$).

Although those not consulting for over 12 months appeared, if anything, to be a fitter group than the more recent consulters, for a few conditions there were no differences between these groups (poor sight, hearing difficulties, incontinence, constipation/loose faeces). There were also no differences between recency of consultation and being housebound or having other difficulties with tasks of daily living. This indicates that the less recent consulters were a group whose 'better' health status should not be over-estimated. Moreover, a substantial minority (between 11% and 27%) of responders who were suffering from many of the listed symptoms but had not reported them (nerves/stress/depression, bronchitis, incontinence, constipation, indigestion/heartburn, aches/pains/stiffness in muscles/joints, sleeplessness, appetite loss and headaches) had not seen their general practitioner for a year or more; in each case they were significantly less likely than more recent consulters to have

reported these problems to their doctors (chi-square test $P<0.05$ to $P<0.001$).

There were no differences between frequency of consultation and the number or type of other professional services received or wanted (for example, nursing services, chiropody, home help, meals on wheels).

Discussion

The study showed that people aged 85 plus years who had not consulted their general practitioner for a year or more prior to the interview reported fewer symptoms and better emotional well-being than other respondents, as measured by a symptom checklist, the general health questionnaire and Neugarten life satisfaction scale. It might be hypothesized, on the basis of the present findings, that those with poorer mental health are more predisposed to be concerned about, or aware of, their physical symptoms, and to present them to their general practitioners. Alternatively, a more positive mental disposition may prevent people worrying about, and reporting symptoms, and from consulting professionals even when they perceive problems; personality factors may be the determining factor in illness behaviour.

In contrast to much of the literature on younger adults, propensity to consult was not related to age, sex, marital status or size or characteristics of social network. Most respondents had sizeable social networks, comprised largely of relatives who provided them with a great deal of practical and social support. It was not therefore possible to adequately test the hypothesis that smaller social networks, and individuals lacking social support, would be more likely to consult their general practitioner in the 12 month period. People aged 85 plus years are a population who have survived, and this may be related to their high level of informal support.

The lack of effect of sex on consultation rates is of interest. The annual general household survey¹ consistently shows that females have higher consultation rates than males. This is confirmed by Cartwright and Anderson's national survey of patients and their doctors, although they show that the sex differences begin to even out at ages 65–74 years, and are even reversed at ages 75 plus years (although based on only 63 responders aged 75 plus years).²⁶ However their finding that sex differences in consultation patterns among elderly people did not reflect those of young adults is consistent with the findings reported here.

Table 3. Current health problems, health status and life satisfaction of respondents according to consultation pattern.

	Percentage of respondents consulting GP in:			Chi-square test
	Last 3 months (n = 314–377)	More than 3 but within 12 months (n = 144–166)	More than 1 year (n = 72–82)	
Experienced a major illness/accident/fall/operation in last 12 months	41	30	22	$P<0.001$
Had a high life satisfaction score (14–20)	30	38	42	$P<0.001$
Had low GHQ score (no psychiatric disturbance)	54	73	74	$P<0.001$
Taking prescribed medication	88	64	56	$P<0.001$
Reported the following current symptoms:				
Constipation	39	28	23	$P<0.01$
Chest pains/other heart trouble	24	20	11	$P<0.05$
Abdominal pain/discomfort	19	10	6	$P<0.01$
Giddyness	38	27	22	$P<0.01$
Aches/pains/stiffness in muscles/joints	74	63	62	$P<0.01$
Sleeplessness	42	35	21	$P<0.001$
Reported 7–15 symptoms	28	18	8	$P<0.001$

n = number of respondents. GHQ = general health questionnaire.

It appears that traditional theories of illness behaviour are not applicable to elderly people and this requires further exploration.

Although the very elderly people in this study who had not consulted their general practitioner for a year or more appeared to be relatively healthier than more recent consulters, this distracts attention from the large amount of possibly manageable morbidity among both groups of consulters which had not been reported to general practitioners. The implication is that opportunistic case finding when people visit the practice is generally not an effective method of providing anticipatory care for very elderly people. It is also not valid to label this group of less recent consulters as 'healthy' given that just under two thirds of them suffered from aches, pains or stiffness in their muscles and/or joints, just under a quarter in each case suffered from constipation, giddiness and sleeplessness, and a similar proportion as the more frequent consulters suffered from problems with functional mobility.

In conclusion, the extent of morbidity and the amount of unreported morbidity in very elderly people is a more valuable index of need than consultation patterns. Rather than focusing on patients who have not consulted the practice for a year or more, as has much of the recent literature, it is suggested here that unreported morbidity be the main variable of interest in studies examining the value of case finding relating to the elderly.

References

- Office of Population Censuses and Surveys. *General household survey 1985*. London: HMSO, 1987.
- Williamson J, Stokoe IH, Gray J, et al. Old people at home: their unreported needs. *Lancet* 1964; 1: 1117-1120.
- Carey GCR. Undisclosed morbidity in persons aged over 70. *J R Coll Gen Pract* 1967; 14: (Suppl. 2) 45-53.
- Burns C. Geriatric care in general practice. *J R Coll Gen Pract* 1969; 18: 287-296.
- Williams EI, Bennett FM, Dixon JV, et al. Socio-medical study of patients over 75. *Br Med J* 1972; 2: 445-448.
- Currie G, Macneill R, Walker J, et al. Medical and social screening of patients aged 70-72. *Br Med J* 1974; 2: 108-111.
- Williams I. A follow up of geriatric patients after socio-medical assessment. *J R Coll Gen Pract* 1974; 24: 341-346.
- Pike LA. Screening the elderly in general practice. *J R Coll Gen Pract* 1976; 26: 698-703.
- Barber J, Wallis J. The benefits to an elderly population of continuing geriatric assessments. *J R Coll Gen Pract* 1978; 28: 428-433.
- Tulloch AJ. Evaluation of geriatric screening — a review. In: Taylor RC, Buckley EG (eds). *Preventive care of the elderly: a review of current developments. Occasional paper 35*. London: Royal College of General Practitioners, 1987.
- Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health. The government's programme for improving primary health care (Cm 249)*. London: HMSO, 1987.
- Ford G, Taylor R. The elderly as under-consulters: a critical reappraisal. *J R Coll Gen Pract* 1985; 35: 244-247.
- Buckley EG, Williamson J. What sort of 'health checks' for older people? *Br Med J* 1988; 296: 1144-1145.
- Taylor RC, Ford GG. The elderly at risk. A critical examination of commonly identified risk groups. *J R Coll Gen Pract* 1983; 33: 699-700.
- Freedman GR, Charlewood JE, Dodds PA. Screening the aged in general practice. *J R Coll Gen Pract* 1978; 28: 421-425.
- Tulloch AJ, Moore VL. A randomised controlled trial of geriatric screening and surveillance in general practice. *J R Coll Gen Pract* 1979; 29: 733-742.
- Ebrahim S, Hedley R, Sheldon M. Low levels of ill health among elderly non-consulters in general practice. *Br Med J* 1984; 289: 1273-1275.
- Williams ES, Barley NH. Old people not known to their general practitioners: a low risk group. *Br Med J* 1985; 2: 445-448.
- Townsend P. *Poverty in the United Kingdom*. Harmondsworth: Penguin Books, 1979.
- Bowling A, Salvage A. With a little help. *Community Care* 1986; 13 March: 24-27.

- Neugarten BL, Havighurst RJ, Tobin SS. Measurement of life satisfaction. *J Gerontol* 1961; 16: 134-143.
- Goldberg D. *Manual of the general health questionnaire*. Windsor: NFER-Nelson, 1978.
- Stokes JP. Predicting satisfaction with social support from social network structure. *Am J Community Psychol* 1983; 11: 141-152.
- Statistical package for the social sciences (SPPSS X)*. Chicago: McGraw Hill, 1983.
- Siegel S. *Nonparametric statistics for the behavioural sciences*. London: McGraw Hill, 1956.
- Cartwright A, Anderson R. *General practice revisited. A second study of patients and their doctors*. London: Tavistock Publications, 1981.

Acknowledgement

The research was funded by City and Hackney Health Authority and Hackney Social Services Department.

Address for correspondence

Dr A. Bowling, Health Services Research Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT.



THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

RESEARCH FUNDING Scientific Foundation Board

Applications are now being received for grants for research in or relating to general medical practice, for consideration at the May 1989 meeting of the Scientific Foundation Board. In addition to its general fund the Board also administers some specific funds including the Windebank Fund for specific research into diabetes.

The Scientific Foundation Board's definition of research is catholic and includes educational research, observational as well as experimental studies, and accepts the methodologies of social science as valid. It is not in a position to fund educational activities.

If the study involves any intervention or raises issues of confidentiality it is wise to obtain advance approval from an appropriate research ethics committee otherwise a decision to award a grant may be conditional upon such approval.

Studies which do not, in the opinion of the Board, offer a reasonable chance of answering the question posed will be rejected. It may sometimes be useful to seek expert advice on protocol design before submitting an application.

Care should be taken to ensure that costs are accurately forecast and that matters such as inflation and salary increases are included.

The annual sum of money available is not large by absolute standards and grant applications for sums in excess of £15000 for any one year are unlikely to be considered.

Application forms are obtainable from the Secretary of the Board at: The Clinical and Research Division, 14 Princes Gate, London SW7 1PU. *The closing date for receipt of completed applications is 12 March 1989; any forms received after that date will, unfortunately, be ineligible for consideration.*